APOC 5/24/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS354AGC	A. BUILDING _____ B. WING _____	C 04/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACHELE SENIOR GUEST HOME	3398 BANCROFT CIRCLE LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 4/27/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, one Category I and five Category II residents. The census at the time of the survey was six. Six resident files were reviewed. One discharged resident file was reviewed. Complaint #NV00025157 was substantiated. See Tag Y0087 The following deficiencies were identified:	Y 000		
Y 087 SS=I	449.199(3) Limitation on Number of Residents NAC 449.199 3. A residential facility must not accept residents in excess of the number of residents specified on the license issued to the owner of the facility. This Regulation is not met as evidenced by: Based on record review and interview on 4/27/10,	Y 087		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 5/20/10

RECEIVED
MAY 20 2010
BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

POC Accepted 5/21/10 APOC

PRINTED: 05/10/2010
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF COF:RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS354AGC	A. BUILDING _____ B. WING _____	C 04/27/2010

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Y 087	Continued From page 1 the facility admitted more residents than allowed by their license. Findings include: The facility applied for and was issued a license for six residents. A review of the facility records on 4/27/10 revealed Residents #1 through #6 were living in the facility when Resident #7 was admitted on 4/21/10. During interviews with the Administrator and Employee #2, they reported that Resident #7 was admitted on 4/21/10 and Resident #3 was transferred to another facility on Sunday 4/25/10. They admitted the facility was over census for a few days. A review of the Medication Administration Records (MARS) on 4/27/10 indicated that medications were administered to Residents #1, #2, #3, #4, #5, #6, and #7 from 4/21/10 through 4/25/10. Severity: 3 Scope: 3	Y 087	Resident # 7 is recently residing at the facility. Resident # 3 was transferred to another facility on 4/25/10. 5/21/10 C Administrator is responsible that facility must not exceed in allowed number issued by the licensing must be reinforced at all times to be in compliant with the bureau. 5/20/10	

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